ARIZONA TRANSPLANT ASSOCIATES, PC

JAMES L. CASHMAN, MD   JEFFREY A. BRINK, MD   WILLEM J. VAN DER WERF, MD   THOMAS CHALY, MD

MEDICAL HISTORY FORM

PLEASE COMPLETE ENTIRE BUBBLE SHEET **(PAGE 1 of 2)**

SCANNED
______
(Office use only)

PATIENT NAME:____ **DOB:**______________

PLEASE FILL IN BUBBLE COMPLETELY (BLACK INK ONLY): EXAMPLE ●

DO NOT ALTER PRE-POPULATED FORM – USE "OTHER" TO ADD COMMENTS, ETC

PERSONAL MEDICAL HISTORY

HAVE YOU HAD A DIAGNOSIS OF: *(multiple choice)*   O **NONE**

- O Chronic Obstructive Pulmonary Disease (COPD)
- O Congestive Heart Failure (CHF)
- O Coronary Artery Disease (CAD)
- O End-Stage Renal Disease (ESRD)
- O Gastroesophageal Reflux Disease (GERD)
- O Hepatitis C
- O Diabetes, Type I – **Age of onset** _____**years**
- O Diabetes, Type II – **Age of onset** _____**years**
- O Symptomatic Peripheral Vascular Disease (PVD) O Yes O No
- O Hypercholesterolemia (HIGH CHOLESTEROL)
- O Hypertension (HIGH BLOOD PRESSURE)
- O Kidney Disease
- O Liver Disease
- O Lung Disease
- O Pancreas Disease
- O Cancer – Type:__________________________
- O **Other**__________________________________

FAMILY HISTORY   O **ADOPTED**

Does your FATHER have a history of:

O Kidney Disease   O Liver Disease   O Pancreas Disease   O **Other**______________________   O **Unknown/None**

Does your MOTHER have a history of:

O Kidney Disease   O Liver Disease   O Pancreas Disease   O **Other**______________________   O **Unknown/None**

SURGICAL/HOSPITALIZATION HISTORY   LIST BELOW   *O NONE*

________________________   ________________________   ________________________
________________________   ________________________   ________________________
________________________   ________________________   ________________________

PERSONAL REVIEW OF SYMPTOMS

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS? *(multiple choice)*   O **NONE**

- O Abdominal Pain
- O Bleeding or Bruising Tendency
- O Blood in Urine
- O Blurred or Double Vision
- O Chronic or Frequent Coughs
- O Diabetes (insulin dependent)
- O Diabetes (non-insulin dependent)
- O Difficulty Walking
- O Excessive Thirst
- O Fatigue
- O Frequent Urination
- O Claudication and/or Cool Extremities and/or Leg/Foot Pain
- O Hearing Loss/Ringing in Ears
- O Heat or Cold Intolerance
- O Joint Stiffness or Swelling
- O Lightheaded or Dizziness
- O Memory Loss or Confusion
- O Nausea or Vomiting
- O Numbness or Tingling Sensation
- O Painful Bowel Movements or Constipation
- O Prolonged Bleeding
- O Rash or Itching
- O Recent Weight Change
- O Shortness of Breath
- O Skin Discoloration
- O Sore Throat or Voice Change
- O **Other**____________________
  ____

HISTORY OF SKIN REACTION OR OTHER ADVERSE REACTION TO:

O Penicillin or Other Antibiotics   O Morphine/Demerol/or Other Narcotics

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MEDICAL HISTORY FORM

PLEASE COMPLETE ENTIRE BUBBLE SHEET **(PAGE 2 of 2)**

SCANNED
______
(Office use only)

PATIENT NAME:______________________________ **DOB:**______________

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SOCIAL HISTORY

TOBACCO/SMOKING USE - Are you a: *(select **ONE**)*

O current smoker   O Smoker   O nonsmoker
O current every day smoker   O current status unknown   O unknown if ever smoked
O current some day smoker   O former smoker   O **Other**____________________

If "current smoker": How many cigarettes a day do you smoke? *(select **ONE**)*

O 5 or less   O 6-10   O 11-20   O 21-30   O 31 or more

If "current smoker": Are you interested in quitting? *(select **ONE**)*

O Ready to quit   O Thinking about quitting   O Not ready to quit

ALCOHOL USE:

Did you have a drink containing alcohol in the past year? *(select **ONE**)*   O Yes O No

If yes: How often did you have a drink containing **alcohol** in the past year? *(select **ONE**)*

O Never   O 2 to 4 times a month   O 4 or more times a week
O Monthly or less   O 2 to 3 times a week

If yes: How many drinks did you have on a **typical day** when you were drinking in the past year? *(select **ONE**)*

O 1 or 2 drinks   O 3 or 4 drinks   O 5 or 6 drinks   O 7 to 9 drinks   O 10 or more drinks

TRANSPLANT PATIENTS LIVER - HISTORY OF LIVER PROBLEMS   *O NONE*

Have you had a liver transplant?   O No   O Yes, when?____________________
Have you ever been jaundiced?   O No   O Yes, when?____________________
Any travel outside the United States?   O No   O Yes, where?____________________
Have you had any signs of internal bleeding?   O No   O Yes

TRANSPLANT PATIENTS KIDNEY – HISTORY OF KIDNEY PROBLEMS   *O NONE*

Have you had a kidney transplant?   O No   O Yes, when?____________________
Do you use peritoneal dialysis (CAPD)?   O No   O Yes, for how long?____________________
Do you use hemodialysis?   O No   O Yes, for how long?____________________
What is your dialysis schedule?   O Monday/Wednesday/Friday   O Tuesday/Thursday/Saturday

ALLERGIES & REACTIONS   LIST ALL ALLERGIES BELOW   *O NO ALLERGIES*

__________________   __________________   __________________
__________________   __________________   __________________
__________________   __________________   __________________

CURRENT MEDICATIONS   LIST ALL MEDICATIONS BELOW   *O No Medications*

__________________   __________________   __________________
__________________   __________________   __________________
__________________   __________________   __________________